ALABAMA MEDICAID AGENCY

WAIVER MEDICAL FORM/
WAIVER SLOT CONFIRMATION FORM

Client's Name: _____

Client's Address: _____

_____

Social Security Number: _____

Operating Agency: _____

Name of Waiver: _____

Waiver Slot Available: Yes: ____ No: ____ Date: _____

Level of Care Approved: Yes: ____ No: ____ Date: _____

Signature and Title of Reviewer: _____

Phone Number of Reviewer: (__)_____

Name and Fax Number for Award Notification: _____

District Office: _____

Fax Number of District Office: _____

Date Application Mailed to District Office: _____

NOTE: LTC ADMISSION NOTIFICATION FORM SHOULD NOT BE TRANSMITTED UNTIL FINANCIAL AWARD NOTIFICATION IS RECEIVED